NC Health Choice
Annual Utilization Study
October 1998 Through September 2001

Introduction

This document provides health care cost and utilization data for members of the North Carolina Health Choice (NCHC) group for services incurred from October 1998 through September 2001. The data have not been adjusted for outstanding claims.

Norms are based on all dependent youth (under age 19) from the State of North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan. Norms have not been age and sex adjusted.

"Costly" admissions (admissions incurring more than $50,000 in allowed charges or with a length of stay in excess of 30 days) have been excluded from utilization rate and charge statistics. However, payment data include these admissions. Table 17 lists the costly admissions.

Because there were so few members in the Extended Coverage segment, their utilization and cost behaviors are not analyzed. However, their data are included in the tables.

Demographics

The average monthly enrollment from October 2000 through September 2001 (FY 2001) was 68,388 members. Non-Copay members comprised nearly two-thirds of this total. The sex distribution of both segments was about half male and half female. About half of all members were between 6 and 12 years old. A slight majority of members were white (52 percent), while 35 percent were black.

Membership rose 4 percent above that of FY 2000 (October 1999 through September 2000).

Inpatient Utilization and Average Charges

Utilization decreased during FY 2001 due to declining utilization in each major segment, particularly in the Non-Copay segment. Utilization was below the norm for both segments.

The average charge per admission fell due to similar decreases for both the Copay and the Non-Copay segments. The average charge per day dropped slightly.

Respiratory diseases was the most prevalent diagnostic category, accounting for more than 20 percent of all admissions. Injury and poisoning, digestive diseases, mental disorders, and endocrine diseases each accounted for another 10 percent of admissions.

Outpatient Utilization and Average Charges

In both the hospital outpatient and ambulatory surgery settings, utilization was below the norm, while emergency department utilization exceeded the norm in FY 2001. Utilization increased slightly for the hospital outpatient and emergency department settings, and remained stable in the ambulatory surgery setting between FY 2000 and FY 2001.

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In the emergency room setting the utilization rates for non-urgent and urgent conditions were well above their norms, while the rate for emergent conditions was much closer to its norm.

In all settings, and in both segments, the average charge per visit was below the norm.

Office Visit Utilization and Average Charges

The office visit utilization rate increased, reflecting increases in the visit rates both to specialists and to primary care physicians. Utilization for both settings was below the norm. On the other hand, the average charge per visit (which increased slightly in both settings) was consistent with the norm.

Overall, outpatient utilization of mental health services was higher than the norm. The drug abuse visit rate rose significantly and was far above the norm in FY 2001.

Payments

Payments per member per month increased in FY 2001 and were slightly higher than the norm. As this is preliminary data which has not been adjusted to account for outstanding claims, it is to be expected that payments and utilization will be higher when all claims have been filed.

Institutional payments for both segments increased slightly due to fairly small increases in utilization and average payments in the hospital outpatient and emergency department settings. For both segments, institutional payments were below the norm.

The increase in professional payments was primarily attributable to higher payments for office visits and prescription drugs. Professional payments were much higher than the norm.

Payments for mental disorders, diseases of the nervous system, respiratory diseases, ill defined conditions, and payments for "other" (including drugs) were all higher than the norm.

Costly admissions (admissions which incurred costs greater than $50,000 or hospital stays greater than 30 days) added nearly $2 to the pmpm payment.